STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003284	A. BUILDING: _____ B. WING _____	C 09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT HEART CENTER OF INDIANA LLC	10580 N MERIDIAN ST INDIANAPOLIS, IN 46290

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one State complaint. Complaint# IN00136058: Unsubstantiated; lack of sufficient evidence. Date of Survey: 9-18-14 Facility Number: 003284 Surveyor: Marcia Anness, RN Public Health Nurse Surveyor St Vincent Heart Center of Indiana is in compliance with 410 IAC 15-1.5-6, Nursing Services and 410 IAC 15-1.6.7, Respiratory Care Services, Hospital Licensure Rules. QA: claughlin 10/30/14	S 000		